September 17, 2015

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Dear Mr. Slavitt, Mr. Macrae, Dr. Mermin and Dr. Cheever:

We are writing on behalf of the HIV Medicine Association (HIVMA) and the Ryan White Medical Providers Coalition (RWMPC) with recommendations to inform the development of your agency's implementation plan for the update to the National HIV/AIDS Strategy (NHAS). HIVMA represents nearly 5,000 physicians, scientists, and other health care professionals working on the frontlines of the HIV epidemic across the U.S. The RWMPC is a national coalition of medical providers and administrators who work in clinics supported by the Ryan White HIV/AIDS Program.

The updated NHAS provides critical direction and important targets to measure progress toward the NHAS goals for 2020. We anticipate that the implementation plan will provide a more detailed roadmap for how we achieve the targets over the next several years. Our comments below are informed by our experience as HIV medical providers and researchers and largely focus on the second goal of increasing access to care and improving health outcomes for people living with HIV. In the addition to the specific recommendations below, we urge all federal agencies to incorporate a social determinants of health framework into their implementation plans to take into account whenever possible the complex social,

environmental, economic and structural factors that affect health care access and health outcomes for patients with HIV infection.

In the spirit of the fourth goal to achieve a more coordinated national response to the HIV epidemic, we are sharing the recommendations for CMS, HRSA and CDC collectively. In addition, we strongly urge all of the federal agencies to prioritize supporting the interoperability of electronic health records with grant reporting and to continue to work toward uniform data reporting requirements to significantly reduce administrative burden so that finite and increasingly limited resources can be devoted to the delivery of services.

HIVMA and RWMPC Recommendations

Goal 1: Reducing New HIV Infections

We urge CMS to:

- Issue updated guidance to state Medicaid directors urging them to add coverage of USPSTF recommended screenings, including routine HIV screening, for traditional Medicaid beneficiaries to reduce disparities in access to preventive care.
- Issue guidance on HIV testing coverage requirements for Qualified Health Plans (QHPs) and monitor coverage of HIV screening by implementing a routine HIV screening measure as part of the Exchange Quality Reporting Program.
- Develop a State Medicaid Director Letter encouraging state Medicaid programs to cover Pre-Exposure Prophylaxis (PrEP) including in their Medicaid managed care contracts.

We urge CDC and SAMHSA to:

- Educate Congress on the public health benefits of syringe access programs.
- Support and promote provider screening of patient drug use and promote stronger linkages and partnerships between HIV providers and substance use treatment programs.

Step 2.A.1 Ensure continuity of high-quality comprehensive health care coverage to support access to HIV care.

We urge CMS to:

- Educate Qualified Health Plans (QHPs), state Medicaid programs and Medicaid managed care plans on the Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents.
- Require unfettered access to antiretroviral drugs by prohibiting utilization management, including prior authorization and step therapy, for antiretroviral drugs prescribed for prevention or treatment.
- Standardize and streamline prior authorization processes and procedures and require prior authorization policies to be clinically justified and not based on controlling costs.
- Develop uniform drug tier standards that cap out-of-pocket costs at a fixed dollar amount for specialty drugs, e.g., $100 or $150 per medication as some states have done. As an example,

beginning in 2016 Covered California will cap out of pocket costs for specialty drugs at $150 to $250 per month for individuals in silver and platinum plans. At least one study suggests that doing so will result in very little or only nominal increases in premiums or other health care costs for the average plan enrollee.[1]

- Continue to support implementation of a uniform set of core HIV quality measure across federal programs and by private insurers. Prioritize at a minimum, monitoring HIV Viral Load Suppression across all payers, including Medicare, Medicaid and the Exchange Quality Reporting System.

We urge HRSA and CDC to:

- Develop policies to ensure access to Pre-Exposure Prophylaxis (PrEP) for individuals without another source of coverage or poor coverage that requires high levels of cost sharing in PrEP clinics and for HIV providers managing care for discordant couples.
- Urge the U.S Preventive Services Task Force to conduct an evidence review and make a recommendation regarding the use of PrEP as a preventive measure with populations at higher risk for contracting HIV infection.

Step 2.A.2 Ensure linkage to HIV medical care and improve retention in care for people living with HIV.

We urge CMS and HRSA to:

- Support demonstration projects evaluating models for leveraging Ryan White, Medicaid and SAMSHA funding to integrate mental health and substance use services into primary HIV care, including Ryan White providers partnering with substance use prevention and treatment programs to provide onsite HIV prevention and care services and vice versa.
- Support access to medical treatments for substance abuse, such as suboxone, buprenorphine and methadone.
- Support demonstration projects that evaluate HIV care teams providing home-based care (and other outreach approaches) to patients who fall out of care or need to be engaged in care and who otherwise are hard to reach.

We urge HRSA to:

- Collect and disseminate innovative strategies and best practices for retaining patients in care from Ryan White grantees. Examples include clinics reviewing out of care patient lists with the care team regularly to identify patients who have moved, died or changed providers while catching those who may have cancelled an appointment but never rescheduled, and developing flexible scheduling programs such as the "Take a Number" program at the John T Carey Special Immunology Unit in Cleveland that dedicates one day a month to patients who have missed three visits in a year to attend "first come, first serve" appointments.

[1] See *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations*. Prepared by Milliman, Inc. Commissioned by the Leukemia and Lymphoma Society. Online at: http://www.lls.org/sites/default/files/National/USA/Pdf/Milliman%20Report%20on%20Prescription%20Cost%20Sharing%20Limits%20for%20Exchange%20Plans.pdf.

- Reconsider HHS's definition of "retention in care" to take into account evolving standards for the appropriate appointment intervals for patients who are virally suppressed and healthier. The current definition that requires a visit in each six month interval for the past 24 months excludes some patients who are virally suppressed and keeping appointments but may not schedule them exactly within the six month intervals.

Step 2.B: Take deliberate steps to increase the capacity of systems as well as the number and diversity of available providers of clinical care and related services to people living with HIV.

We urge HRSA and CMS to:

- Promote policies including for payment that support team-based care allowing all team members, including nurse practitioners and physician assistants, to work to the full extent of their training.
- Promote policies and best practices that utilize PharmDs in supporting treatment adherence.
- Support existing Ryan White-funded medical providers with building formal business partnerships and referral agreements with primary care providers, including Federal Qualified Community Health Centers (FQHC), through a variety of mechanisms. Provide detailed information and examples of effective partnership models, including expanded access to telemedicine (such as Project ECHO) by promoting parity in reimbursement for Medicaid and other payers for telemedicine and other long-distance co-management relationships.
- Evaluate models for providing access to case management and other psychosocial support services to primary care providers to expand their capacity to manage patients living with HIV through the Center for Medicare and Medicaid Innovation and in conjunction with HRSA. A challenge frequently reported by primary care providers, including FQHCs, to providing HIV care is not having access to resources to support case management and provide necessary psychosocial supports to patients with HIV infection.

We urge HRSA and CDC to:

- Release HIV/AIDS Bureau Workforce Survey results and the results of the Medical Monitoring Project (MMP) workforce survey and convene a consultation with HIV clinicians to make recommendations and develop an action plan to build the capacity of the HIV clinical workforce.
- Sponsor a consultation with public health officials, HIV providers/health care professionals, FQHCs, AETCs, and Primary Care Associations to identify recommendations and best practices for addressing HIV prevention and care needs in rural and/or low incidence areas. This is particularly important given the new focus on populations and communities of high impact. The HIV and HCV outbreak in Scott County, Indiana underscores the need for a baseline public health safety-net that includes HIV/ID providers and other health care professionals throughout the country, including in rural communities.

We urge HRSA to:

- Issue regulations revising the HRSA criteria used to designate medically underserved areas/populations and health profession shortage areas based on the recommendations of a

majority of the members of the 2010/2011 Negotiated Rulemaking Committee. The recommendations included incorporating criteria that took into account clinics serving special populations, including people with HIV and individuals who are LGBT. See: http://www.hrsa.gov/advisorycommittees/shortage/

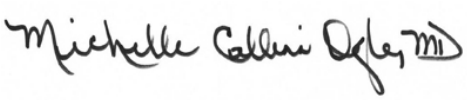
- In the National Health Service Corps Job Center, add a data field to indicate whether a site receives Ryan White Program funding to provide medical care to people with HIV to allow job seekers interested in pursuing careers in HIV medicine to identify sites where they can build on their HIV patient care experience.
- Renew funding (http://www.hrsa.gov/about/news/pressreleases/110907hivtraining.html) for HIV-specific training within primary care residencies (family medicine, internal medicine, pediatrics, obstetrics/gynecology) to attract physicians to HIV medicine early in their careers.

We urge CMS to:

- Address Medicaid payment disparities by supporting a reinstatement of the enhanced Medicaid payment rates for primary care services and continuing to evaluate financing models that adequately support management of complex conditions like HIV infection.
- Promote implementation of the Medicaid health home benefit for people with HIV and disseminate information, including evaluation results for states that have implemented health home programs.

HIVMA and RWMPC are looking forward to partnering with HRSA, CMS and CDC on implementing the next phase of the NHAS and moving our nation closer to the ultimate goals of appropriately treating everyone living with HIV and making new HIV infections in the U.S. rare. If you have questions or need additional information, please contact Andrea Weddle, HIVMA's Executive Director, at aweddle@hivma.org, or Jenny Collier, RWMPC's Convener, at jennycollierjd@yahoo.com.

Sincerely,



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